Before the
FEDERAL COMMUNICATIONS COMMISSION
Washington, D.C. 20554

In the Matter of	)	
	)	
Rural Health Care Support Mechanism	)	WC Docket No. 02-60

COMMENTS OF THE OREGON HEALTH NETWORK

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SUMMARY

OHN is a non-profit organization created to build Oregon's first state-wide broadband health care network. With the benefit of a $20.182 million Rural Health Care Pilot Program funding award, OHN has implemented a growing network with 236 health care and health education facility participants, of which 152 are currently connected. OHN's network provides secure, scalable and monitored broadband services which are necessary for the provisioning of broadband for health care.

OHN urges the Commission to take an active role in supporting national health information technology goals by implementing long-awaited reforms to the Rural Health Care universal service support mechanism. These changes are needed so that OHN and other networks created as part of the Pilot Program can continue to grow, and so new networks can be created that will bring the benefits that Oregon residents are beginning to enjoy. OHN is concerned, however, that legacy rules governing the traditional Rural Health Care program are outmoded and ineffective and, in some cases, promote the inefficient use of scarce universal service funding.

OHN urges the Commission to adopt the Health Broadband Services Program ("HBSP") which it proposed in 2010 but with changes that maintain policies from the Pilot Program that have proven effective, such as the 85% subsidy, the eligibility of urban health care providers, and the ability to apply for funding as a consortium. OHN also urges the Commission to ensure that network management services and network operations centers remain eligible for funding, and to expand eligibility criteria to include nominally for-profit rural clinics and physician practices. Finally, OHN urges the Commission to avoid specifying minimum or maximum bandwidth standards for health care providers as bandwidth requirements are changing too quickly for such standards to be useful or helpful.

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The Oregon Health Network ("OHN"), by its attorney, hereby submits these further comments in response to the Federal Communications Commission's ("FCC" or "Commission") Notice of Proposed Rulemaking, FCC 10-125, released July 15, 2010, in the above captioned proceeding.[1] The purpose of these comments is to introduce updated information into the record to reflect developments since OHN filed its comments during the fall of 2010.[2]

INTRODUCTION

OHN is a non-profit organization created to build Oregon's first state-wide broadband health care network. OHN was the recipient of a $20.182 million Rural Health Care ("RHC") Pilot Program ("Pilot" or "Pilot Program") funding award. OHN leveraged this award to competitively obtain scalable and monitored broadband services on behalf of hundreds of health care and health education providers across the state. This bulk purchase stimulated broadband investment by local service providers, especially in rural areas, thereby increasing broadband access and driving down the cost of broadband connectivity for health care providers and providing an indirect benefit to surrounding communities. OHN ultimately intends to connect all health providers that are critical to the delivery and access to health care and health care

[1] *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Notice of Proposed Rulemaking, 25 FCC Rcd 9371 (2010) (*RHC NPRM*).

[2] *See OHN Comments*, WC Docket No. 02-60 (filed Sep. 8, 2010) (*OHN Comments*).

education in the largely rural and geographically diverse State of Oregon. Currently OHN has 236 health care and education facilities, 152 of which are actively connected to the network and to OHN's network operations center.[3]

OHN is a success story because of the Commission's bold action and foresight when it conceived the Pilot Program in 2006.[4] Yet for OHN to continue to grow, the Commission must quickly establish improved and permanent rules for the Rural Health Care program and avoid another year of uncertainty for health care providers who are trying to join a future based on the broadband-dependent services that are necessary to deliver better health care at reduced costs. Indeed, the Commission has recognized that a robust, easy to navigate RHC program is essential to realizing national Health Information Technology (Health IT) goals.[5] Accordingly, in these comments OHN urges the Commission to again act boldly by promptly implementing many of the reforms to the RHC program it proposed almost two years ago.

Specifically, and in light of new information available since these reforms were first proposed, OHN urges the Commission to do the following:[6]

- Adopt a subsidy of 85% for broadband services;
- Allow urban health care providers that are part of a network with rural participants to receive subsidies for broadband services;

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[3] *See* http://www.oregonhealthnet.org/content/active-members (last checked May 23, 2012).

[4] *See Rural Health Care Support Mechanism*, WC Docket No. 02-60, Order, 21 FCC Rcd 11111 (2006); *see also Rural Health Care Support Mechanism*, WC Docket No. 02-60, Order, 22 FCC Rcd 20360 (2007) (*Pilot Program Selection Order*).

[5] *See generally FCC, Connecting America: The National Broadband Plan*, GN Docket No. 09-51, Health Care, Chapter 10 (2010) (*National Broadband Plan*); *id*. at 217 ("[I]t will be critical for the FCC to play a more prominent and sustained role in evaluating broadband infrastructure and in supporting the nation's health transformation.").

[6] In addition to the issues identified below, OHN reiterates other issues set forth it its NPRM comments filed in September 2010. *See OHN Comments*.

- Allow support for network operations centers ("NOCs") or NOC services which will ensure that health broadband networks are able to deliver the quality of service necessary for integrated health care delivery;

- Expand the definition of health care provider to include clinics that meet the definition of "public health provider" which will align with the policy and eligibility definitions of the Centers for Medicare & Medicaid ("CMS");

- Ensure that rules and administrative processes fully support consortium applications;

- Do not impose static minimum or maximum bandwidth requirements in light of rapidly growing demand and rapidly changing technologies.

I. REFORMS TO THE RURAL HEALTH CARE PROGRAM ARE URGENTLY NEEDED

OHN recognizes that over the last two years the Commission has been active reforming the three federal universal service fund ("USF") programs besides the RHC program. OHN also respects that the Commission wants and needs to ensure that it adopts the "right" policies for a reformed RHC program. But almost two years after the *RHC NPRM* and *nine years* since the last significant reforms of the RHC program,[7] this is a classic case of "the perfect" being the enemy of "the good." The need is urgent and the record in the RHC docket provides sufficient recent and relevant information – much of it uncontested – to justify bold action. Accordingly, now is the time for the Commission to act on RHC reform.

A. The Commission Must Play an Active Role in Supporting National Health Information Technology Goals

Two years ago, the FCC's *National Broadband Plan* justifiably recognized the critical role the Commission must play in supporting national Health IT policies that depend on the availability of high speed, reliable and scalable connectivity, and the broadband-dependent

[7] *See Rural Health Care Support Mechanism*, WC Docket No. 02-60, Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking, 18 FCC Rcd 24546 (2003) (*2003 Report and Order and FNPRM*).

technologies and services that are required to deliver the next generation of health care.[8] While the Commission waits to implement these recommended USF reforms targeted to health care, the specific benefits of, and need for, broadband specially configured for health care grow increasingly plain.[9] In addition, on a parallel track, national Health IT policies designed and implemented by the Department of Health and Human Services ("HHS") continue to place significant connectivity demands on health care providers.[10] As HHS Secretary Sebelius explained a little over one year ago:

> There is urgency to increase broadband access to health care providers. By statute, HHS meaningful use incentive payments will only be available for a limited time. Beginning in 2015, Medicare will pay health care providers less if they do not meaningfully use [electronic health records ("EHRs")]. Without targeted support over the next two years, this could have a great impact on rural America because of the large Medicare population that rural health care providers typically serve.[11]

There is simply no question that USF support targeted to ensure access to advanced services for rural health care providers is more important than ever before.

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[8] *See National Broadband Plan* at 213 ("[B]ecause of health care's role in the lives of consumers and its importance to the national economy, it is critical to retain a dedicated set of programs within the [USF] to help spur broadband adoption by health care providers. The FCC's Rural Health Care Program as currently structured, however, is not meeting the country's needs").

[9] *See, e.g.*, OHN, WC Docket No. 02-60, *Notice of Ex Parte Communication*, at 3-7 (dated Feb. 24, 2012) (*OHN Ex Parte*) (listing benefits to OHN members including increased operational efficiencies, actual and expected direct cost savings, increased distance learning and training opportunities, and improved patient care).

[10] *See, e.g.*, National Rural Health Resource Center staff, WC Docket No. 02-60, *Notice of Ex Parte Communication*, at 1 (Dec. 8, 2011) (summary submitted Dec. 27, 2011 by Chin Yoo, Attorney Advisor, Telecommunications Access Policy Division (TAPD), Wireline Competition Bureau (WCB)) (*NRHRC Ex Parte*) ("rural health care providers may not be capable of meeting EHR meaningful use requirements if adequate broadband capacity is not available."); Hank Fanberg, CHRISTUS Health, WC Docket No. 02-60, *Notice of Ex Parte Communication* (Dec. 12, 2011) (summary submitted Jan. 17, 2012 by Linda Oliver, Attorney Advisor, TAPD, WCB) ("Health Information Technology for Economic and Clinical Health (HITECH) Act requirements are creating another source of demand for bandwidth") *and* HITECH Act Timeline (Attached as Exhibit A to these comments).

[11] *See* Letter from Kathleen Sebelius, Secretary, HHS, to Julius Genachowski, Chairman, FCC, at 1 (Apr. 18, 2011) (*Sebelius Letter*).

Notwithstanding the reasons for the current RHC policy impasse, it is imperative that the Commission act to reform the RHC program. OHN and other Pilot Projects provide collective testimony that the demand for health broadband is growing rapidly. For example, while OHN connected locations have minimum connections of 10 Mbps (82% fiber) with quality of service necessary for health care, OHN is already seeing a trend toward greater bandwidth demand.[12] The Commission can and should stay in front of this expected demand by promptly implementing RHC program reforms.

B. Prompt Commission Action Will Create Needed Certainty and Provide the Necessary Time to Implement Significant Changes to the Rural Health Care Program

Like OHN, many Pilot projects are successfully using RHC funding to drive down the costs and increase access to broadband for health care providers across their states and regions. For example, the record clearly shows that bulk contracting through competitive RFPs at a consortium level has delivered these benefits across the country.[13] No further data gathering or analysis is needed to recognize this and many of the other benefits of RHC reforms. On the other hand, further delays in reforming the RHC program will not only prevent OHN and other

[12] *See also, e.g.,* Letter from Eric P. Brown, President and Executive Officer, California Telehealth Network (CTN), to Marlene H. Dortch, Secretary, FCC, WC Docket No. 02-60, *Notice of Ex Parte Communication*, at 1 (dated Feb. 24, 2012) (noting "CTN member sites are selecting higher capacity broadband circuits than originally envisioned"); Dr. Jacob Reider, M.D., Senior Policy Advisor, Office of the National Coordinator for Health Information Technology, HHS, WC Docket No. 02-60, *Notice of Ex Parte Communication*, at 1 (Dec. 14, 2011) (summary submitted Jan. 6, 2012 by Linda Oliver, Attorney Advisor, TAPD, WCB) (noting "bandwidth needs [for rural health providers] are significant and growing, increasing almost daily as new applications become available"); Brock Slabach, Senior Vice President of Member Services, National Rural Health Association (NRHA), WC Docket No. 02-60, *Notice of Ex Parte Communication*, at 1 (Dec. 7, 2011) (summary submitted Dec. 21, 2011 by Christianna Lewis Barnhart, Attorney Advisor, TAPD, WCB) (*NRHA Ex Parte*) (noting "broadband needs [of rural health providers] are likely to grow in the future as applications are developed and deployed").

[13] *See* Letter from Craig Davis, Vice President, Rural Health Care Division, Universal Service Administrative Company (USAC), to Sharon Gillett, Chief, WCB, FCC, WC Docket No. 02-60, at 2-3 (Mar. 14, 2012) (*USAC Pilot Program Observations*) (listing benefits); *see also, e.g., NRHA Ex Parte* at 1 (noting that "some health care providers do not apply or do not complete the [individual provider] application process due to personnel issues" and that "permitting providers to apply as part of a consortium application would be of great help, especially for smaller providers such as rural health clinics").

networks funded through the Pilot Program from growing, but risks undermining the hard won benefits already being realized by these networks. The Commission should not allow RHC program uncertainty to continue for thousands of health care providers that are benefitting or potentially benefitting from the Pilot Program.[14]

Notably, the Wireline Competition Bureau's recent bridge funding proposal is a temporary measure that will not postpone the need for the Commission to act now on longer term RHC reform.[15] The Bureau recognized that bridge funding is needed because many existing Pilot Program networks may not be sustainable if forced to obtain support under the legacy "Primary" RHC program rules.[16] However, if RHC reforms are not in place by July 1, 2013, more bridge funding will be needed for even more Pilot projects – *i.e.*, funding will be needed for those projects who exhausted recurring support in the 2013 funding year (beginning July 1, 2012) *and* those projects who will exhaust recurring support in the 2014 funding year (beginning July 1, 2013). This new group of Pilot projects needing bridge funding would include OHN which will exhaust its Pilot Program support in May 2014.

In addition, Pilot Program bridge funding does not postpone the need for prompt Commission action because it may take up to twelve months to make the administrative changes necessary for successful implementation of any significant RHC program reforms.[17] This

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[14] *See* Letter from Craig Davis, Vice President, Rural Health Care Division, USAC, to Sharon Gillett, Chief, WCB, FCC, WC Docket No. 02-60, at 1-2 (May 4, 2012) (*USAC Pilot Program Data*) (noting as of January 31, 2012, USAC has issued Pilot Program funding commitments to 2,106 out of the 6,477 eligible health care providers participating in the Pilot Program).

[15] *See* Public Notice, *Wireline Competition Bureau Seeks Comment on Funding Pilot Program Participants Transitioning out of the Rural Health Care Pilot Program in Funding Year 2012*, WC Docket No. 02-60, DA 12-273 (rel. Feb. 27, 2012) (*Bridge Funding PN*) (proposing funding for Pilot projects that are receiving RHC support for recurring monthly costs and that will exhaust that support during RHC funding year 2012 (July 1, 2012 through June 30, 2013)).

[16] *See Bridge Funding PN* at ¶ 4 (noting difficulty in obtaining support from legacy RHC program given differences in rules from the Pilot Program).

[17] *See USAC Pilot Program Observations* at 8.

includes time needed to develop revised programmatic forms and application processes, create or reengineer IT systems, develop internal administrative processes, and conduct adequate education and outreach regarding the new rules. (Experience with the Pilot Program suggests the critical importance of allowing sufficient time for education and outreach.) The lead time needed for the successful implementation of significant program changes means that a failure by the Commission to enact reforms by the third quarter of 2012 risks a delay of up to two years before RHC reforms could be implemented (*i.e.*, until the RHC funding year beginning July 1, 2014).

Such delay and continued uncertainty could erode network membership thereby undermining OHN and other Pilot Program networks. For example, the Colorado Pilot Project networks recently explained:

> The delay in issuing final rules for the revision of the health care support mechanisms of the [USF] is imposing a hardship on our pilot programs and our participating health care providers. That hardship is the uncertainty of funding continuity and the rules under which it will be provided. Our programs are not able to garner the full confidence of our members when we are unable to state unequivocally that our program will continue to receive federal support.[18]

The South Carolina Pilot project noted similar concerns and explained that it has lost potential network members due to uncertainties over future funding.[19] OHN can affirm that, for the same reasons, continued uncertainty regarding the RHC rules-of-the road will undermine the growth and sustainability of its network. Accordingly, OHN urges the Commission to act by the third

[18] *See* Letter from George DelGrosso, Executive Director, Rocky Mountain HealthNet, and Steven Summer, President and CEO, Colorado Health Care Connections, to Christianna Lewis Barnhart, Attorney Advisor, TAPD, WCB, WC Docket No. 02-60, at 3 (dated Feb. 28, 2012) (*CoTN Letter*).

[19] *See* Comments of W. Roger Poston, II, Ed.D, on behalf of the Palmetto State Providers Network (PSPN) and the Medical University of South Carolina, WC Docket No. 02-60, at 1 (dated Mar. 27, 2012) (*PSPN Bridge Comments*) (Noting PSPN has "actually lost HCPs considering membership because we could not provide them with an accurate discount rate and a reliable estimate of their monthly charges, post-Pilot program funding.")

quarter of 2012 to enact long-term reforms and thereby ensure that a further round of bridge funding will not be necessary.

C. Legacy RHC Program Rules Are Increasingly Obsolete and Promote the Inefficient Use of Scarce USF Funds

Another critical reason for the Commission to move forward now with RHC reforms is that current RHC spending outside of the Pilot Program (and outside of Alaska) is discouraging the adoption of high-speed broadband by health care providers, discouraging the formation of networks or, where networks are formed, creating incentives to design them inefficiently. This occurs because the "urban-rural difference" calculation on which support is based in the legacy RHC program often provides greater support for low bandwidth connections. Indeed, as USAC itself recently noted in discussing the advantages of having urban sites eligible in the Pilot Program:

> [Health care providers ("HCPs")] who wish to create a tele-health network in the Primary Program may be incentivized to design a network to maximize funding by ensuring that all connections within the network terminate at an eligible rural entity, resulting in network inefficiencies.[20]

RHC Subject Matter Experts ("SMEs") have noted concerns that the legacy RHC program disfavors higher bandwidth connections. For example, one SME working in rural Montana explained:

> It has been my experience that the Primary program supports the use of more traditional bandwidth connectivity[:] T-1, bonded T-1's and DS3. The urban rate for T-1's provides a very favorable discount. More advanced services are disadvantaged in that the urban-rural rate difference does not provide the needed level of discount.[21]

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[20] *See USAC Pilot Program Observations* at 5.

[21] *See* Comments of Thelma McLusky Armstrong, RN, MS, USAC, RURAL HEALTH CARE PILOT PROGRAM, DOCKET NO. 02-60, HEALTH CARE PROVIDER BROADBAND NEEDS ASSESSMENT SUMMARY, at 14 (rel. Apr. 12, 2012) (*USAC Needs Assessment*); *see also Comments of Jason Wulf* (from Avera Health), *id.* at 18 ("The urban rate seems to favor lower bandwidths. Our experience with DS3's is that the urban rate has been higher than the rural rate except in a few high cost locations.").

Given the pressure on the USF, the Commission's overall broadband goals, and the systemic changes underway in the nation's health care system, the Commission should not maintain policies that potentially discourage broadband deployment or that promote the inefficient use of scarce USF funds.[22]

II. THE COMMISSION SHOULD BUILD ON RURAL HEALTH CARE POLICIES THAT HAVE PROVEN SUCCESSFUL

OHN applauds the Commission for its ongoing efforts assessing the Pilot Program and consulting with RHC program stakeholders and SMEs. The fruits of these efforts are reflected in the many recent letters, comments, and *ex parte* notices filed in the RHC docket. As a result, there is now a robust record supporting many of the long-term reforms the Commission previously proposed.[23] While OHN previously supported certain of these reforms, OHN urged the Commission at the time to make certain changes. Following, OHN provides updates to some of these recommendations in light of new information in the RHC docket.

A. The Commission Should Maintain the Current Pilot program Subsidy Level of 85% for Broadband Services

The Commission originally proposed that the HBSP discount would be 50%. Although no specific rationale was provided for a 50% subsidy level, the Commission indicated that historically it had acted "conservatively" regarding the appropriate discount.[24] At the time, OHN recommended the Pilot's 85% support level be maintained, noting that "Oregon's experience has

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[22] OHN is not proposing the Commission eliminate the legacy RHC program, only that the Commission establish alternative RHC funding mechanisms such as the proposed HBSP which would better encourage broadband deployment, particularly in the lower 48.

[23] In addition, the Commission is also now able to address criticisms regarding its oversight of the RHC program identified by GAO back in 2010. *See* U.S. Government Accountability Office Report: FCC's Performance Management Weaknesses Could Jeopardize Proposed Reforms of the Rural Health Care Program, GAO-11-27 (2010) (available at http://www.gao.gov/products/GAO-11-27).

[24] *See RHC NPRM*, 25 FCC Rcd at 9407, ¶ 91.

been that rural health care providers will struggle to come up with even a . . . 15% match."[25] With two years of further hard won experience under the Pilot program, the needs and realties facing current and potential OHN members have not changed.

Significantly, other Pilot projects, stakeholders, and SME's appear nearly unanimous in emphasizing either the general broadband affordability challenges, especially for rural hospitals, or the importance of specifically continuing the 85% discount level currently available in the Pilot program. For example, SMEs from the non-profit National Rural Health Resource Center note that many critical access and rural hospitals continue to face financial challenges.[26] One Pilot Project has noted that this subsidy provided a critical threshold that resulted in participation in the network.[27] Another recently explained that the 85% discount level is important because anti-kickback laws prevent hospitals from recouping network costs through physician referral fees.[28]

B. Urban Health Care Providers Should Be Eligible for Continued Rural Health Care Program Funding

Due to the changing health care delivery landscape and national goals focusing on health systems integration, the delineation of urban and rural in the health care context is increasingly irrelevant. Urban centers house the specialists and additional resources needed to support the rural areas and therefore are integral to any well-laid national Health IT strategy. Moreover, the record shows that a critical aspect of the success of the Pilot Program was allowing urban health

[25] *See OHN Comments* at 9-10.

[26] *See NRHRC Ex Parte* at 2.

[27] *See CoTN Letter* at 2.

[28] *See Comments of Geisinger Health System*, WC Docket No. 02-60, *Notice of Ex Parte Communication*, at 2 (Feb. 24, 2012) (summary submitted Mar. 26, 2012 by Linda Oliver, Attorney Advisor, TAPD, WCB).

care providers to eligible for support. USAC recently summarized the benefits of allowing urban eligibility:

- Encouraged efficient network design;
- Provided leadership and resources that benefitted smaller and rural participants;
- Urban sites could afford to invest in equipment that allowed development of a centralized networking "hub" that benefitted rural participants.[29]

Consistent with USAC's observations, OHN's success to date is based upon understanding that the next generation of health care requires multiple providers from various states and national regions to work together to improve population health, improve the patient experience, and reduce costs. FCC policies for the RHC program must keep these goals and emerging realities at the forefront.[30] Thus OHN supports a continuation of the Pilot Program rule allowing urban locations to receive RHC support to the extent they are part of a network with a non-de minimus number of rural participants.[31] For example, such a rule should allow a network like OHN to bid services on behalf of a group of urban eligible health care providers to the extent the network they are joining (*i.e.*, the existing consortium) contains a minimum number of eligible rural participants.

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[29] *See USAC Pilot Program Observations* at 4-5.

[30] National health reform efforts are increasingly organized around the "triple aim" goals of improving the experience of health care, improving the health of populations, and reducing the per capita costs of health care. To see how these goals are being implemented in Oregon, see this summary of the Oregon Association of Hospitals and Health Systems 2011-2014 Strategic Plan. (Available at http://www.oahhs.org/about-us/strategic-plan/2011-2014-strategic-plan.pdf.)

[31] *See Pilot Program Selection Order*, 22 FCC Rcd at 20384-85, ¶ 50.

C. Network Operations Centers and Network Management Services Should Continue to Be Eligible for Rural Health Care Program Funding

OHN obtains NOC services through a NOC services contract which, under Pilot Program rules is eligible for RHC support.[32] OHN's NOC is critical to ensuring OHN's many competitively selected vendors meet their service level commitments ("SLCs") to OHN and to individual health care providers on the network. Not only are these uniform SLCs critical, but OHN's independent, vendor agnostic NOC allows maintenance of the SLCs to be pro-actively monitored and thereby spot problems before they potentially impact patient care. In addition, having a vendor-agnostic NOC minimizes potential vendor disputes and finger-pointing.

To ensure that NOC services continue to be supported, the Commission should clarify that the proposed definition of "broadband access service" includes competitively bid NOC services.[33] In this way, OHN would be able to obtain the support necessary to continue to provide affordable NOC services to its network participants.

D. Rural Clinics and Rural Physician Practices Should be Classified as Public Health Providers Eligible for Rural Health Care Program Funding

OHN has previously urged the Commission to consider recognizing certain nominally "for-profit" rural practitioners as eligible rural health clinics.[34] OHN explained:

> We are very concerned that a small rural clinic run by a single physician that technically is for-profit because it has not been incorporated is not the same as a large urban for profit clinic with 100 clinicians. Many of these rural clinics are federally designated Rural Health Centers. The

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[32] *See Pilot Program Selection Order*, 22 FCC Rcd at 20397-98, ¶ 74 ("Recurring and non-recurring costs of operating and maintaining the constructed network are also eligible [for Pilot Program support] once the network is operational.").

[33] *See RHCP NPRM*, 25 FCC Rcd at 9442, proposed rule § 54.631(b) ("'broadband access service' is any advanced telecommunications or information service that enables rural health care providers to post their own data, interact with stored data, generate new data, or communicate over private dedicated networks or the public Internet for the provision of health IT.").

[34] *See OHN Comments* at 11; *see also, e.g.*, Letter from Jeffrey Mitchell, Counsel for OHN, to Marlene Dortch, Secretary, FCC, WC Docket No. 02-60, attachment entitled "OHN eligibility of rural for-profits" (filed Nov. 22, 2010) (*OHN November 2010 Ex Parte*).

> communities and regions they serve are dependent upon them for care. Financially they are often worse off than their non-profit or health district counterparts. In Oregon over 50% of the RHC designated clinics are technically for profit. Most are struggling to stay open. They can ill afford the needed investment for telecommunications infrastructure. We recommend that the FCC consider using the precedent they set by allowing eligibility for the Emergency Departments of for-profit hospitals based on the fact that they had to serve everyone who came into the Department for care regardless of insurance status. If the for-profit RHCs can show that they serve all patients regardless of insurance status, they too should be given eligibility.[35]

The Commission partially answered the question of what is a "public health provider" in 2003 when it concluded that Emergency Departments in rural for-profit hospitals are eligible for RHC support as "rural health clinics."[36] OHN has suggested that clinics that serve the public regardless of insurance status or clinics that serve a certain percentage patients receiving Medicare and Medicaid should be considered public health care providers. The *National Broadband Plan* made a similar proposal and recent comments from stakeholders continue to urge the Commission to move in this direction.[37]

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[35] *OHN Comments* at 11. The 1996 Telecommunications Act clearly provides the FCC with authority to conclude that under certain circumstances for-profit clinics may be eligible for RHC support under either 254(h)(1)(A) or 254(h)(2)(A). First, Section 254(h)(1)(A) ensures the provision of discounted telecommunications services to "any public or nonprofit health care provider that serves persons who reside in rural areas." This clearly recognizes that providers of health care to the public, *i.e.*, "public health providers," can be eligible for discounted telecommunications services. Regarding access to "advanced telecommunications and information services" (*i.e.*, broadband services), Section 254(h)(2)(A) directs the Commission to establish rules to enhance the availability of such services to "all public and non-profit [schools], health care providers, and libraries." While the use of "and" rather than "or" might be interpreted to require that eligible health care providers must be public *and* non-profit, it is just as logical – and would be consistent with the plain meaning of Section 254(h)(1)(A) – to interpret Section 254(h)(2)(A) to require the Commission's rules enhancing access to broadband services to benefit both public health care providers *and* non-profit health care providers. *See also OHN November 2010 Ex Parte* (citing, among other things, *2003 Report and Order and FNPRM*, 18 FCC Rcd at 24553, ¶¶ 13-14.

[36] *See 2003 Report and Order and FNPRM*, 18 FCC Rcd at 24553-55, ¶¶ 13, 16.

[37] *See National Broadband Plan* at 216 (suggesting tying for-profit eligibility to Medicate beneficiary patient volumes); *see also, e.g.,* Comments of W. Roger Poston, II, Ed.D, on behalf of PSPN and the Medical University of South Carolina, WC Docket No. 02-60, at 1 (dated Feb. 23, 2012) (*PSPN Comments*) ("Most of the RHCs and practices are either PA or LLC organizations and it will be extremely difficult for them to become Non-Profit, 501(c)(3) organizations. These HCPs and RHCs, while private, also serve as a public resource for healthcare, much the same as dedicated Emergency Departments in rural for-profit hospitals which are currently eligible").

E. Consortium Applications Must Be Supported and Encouraged

FCC rules have long-recognized Consortia as eligible participants in the RHC program.[38] Unfortunately, however, RHC programmatic forms – and the USAC administrative processes designed around those forms – do not support consortium applications.[39] In contrast, the Pilot Program is designed around a consortium application process that allows the consortium to file application forms and identify consortium members through a series of attachments to a single application for funding.

USAC itself has identified a number the advantages for consortium filings including:

- Only needing to issue a single funding commitment letter ("FCL") per consortium rather than potentially hundreds;
- The cost benefits brought by bulk purchase of services when consortium members are known at the competitive bidding stage (as was the case with the Pilot Program);
- Having a single lead entity responsible for the network provides a single point of contact and facilitates more effective communication between USAC and consortium members;
- Easier substitution of sites and services at a network level, thereby allowing network participants to change bandwidth levels and allowing participants to join or leave the network (USAC notes that in the legacy RHC program "any modification requires new application and new funding commitment for each HCP impacted.")[40]

Notably, USAC identified no negative characteristics of a consortium model.

With hundreds of members and no support for administrative costs, OHN could not be managed using anything other than a consortium model. SMEs and other Pilot projects have also

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[38] *See* 47 C.F.R. § 54.601(a)(2)(vii) (consortia of eligible health care providers ("HCPs") are eligible to receive supported services); *see also* 54.601(b)(1) (HCPs may join consortia).

[39] *See, e.g.*, 2011 FCC Form 465 Instructions at 3 (requiring each HCP to identify the consortium to which it belongs but requiring the HCP itself to file the 465), available at http://www.usac.org/_res/documents/rhc/pdf/forms/2011/Form-465-FY2011-instructions.pdf; *see also USAC Pilot Program Observations* at 2-4.

[40] *See USAC Pilot Program Observations* at 2-4.

identified concrete benefits associated with consortium filings including: reduced paper work for both USAC and health care providers during the invoicing process;[41] small health care providers who lack staff to administer RHC program paperwork benefitted from consortium participation;[42] consortium filing increased the interest by health care providers to participate in the RHC program;[43] and many rural hospitals benefitted from consortiums who help them understand broadband needs.[44]

OHN's own experience validates each of these benefits and OHN thus urges the Commission to establish regular forms and USAC processes that will encourage consortium applications. Indeed, the lack of a consortium filing ability in the legacy RHC program may itself explain the lack of participation in that program. In Oregon and Colorado, for example, levels of RHC program participation grew dramatically in response to the Pilot Program.[45] We agree with CoTN that this growth was due in significant part to the consortium model which allowed small rural sites to let the consortium lead handle many aspects of their network participation for them, including USAC paperwork, service provider and network troubleshooting, and general consulting about what type of services to obtain and how best to utilize them.[46]

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[41] *See, e.g., PSPN Bridge Comments* at 2 (avoids the need to submit "hundreds of invoices per month from one local network").

[42] *See, e.g., NRHA Ex Parte* at 1 (noting benefits of consortium application option, especially for smaller providers such as rural health clinics that have fewer administrative resources and higher staff turnover); *PSPN Bridge Comments* at 2 (noting lack HCPs "lack of resources or time to navigate [the RHC] program process").

[43] *See CoTN Letter* at 2 (noting growth from 10-15 RHC participants statewide to over 200).

[44] *See NRHA Ex Parte* at 1.

[45] *See* fn. 42, *supra.*

[46] OHN also notes that consortium-based networks are generally more technically complex and that it is therefore important for USAC to ensure its staff has sufficient background and expertise in telecommunications as well as health care and Health IT. *See OHN Ex Parte* at 5.

Finally, OHN urges the Commission to provide support for administrative costs for networks like OHN. Administrative support could be provided by either allowing networks obtaining leased connectivity to apply as projects in the proposed Health Infrastructure Program (as OHN previously urged[47]) or, for example, by allowing a reimbursement for one-time administrative costs in the proposed HBSP based on, for example, the number of HCPs that are part of a consortium's Form 465.

F. The Commission Should Avoid Specifying Minimum or Maximum Bandwidth Standards

Bandwidth demands in the health care industry are clearly increasing, but they also change almost daily. Therefore, the Commission should avoid establishing requirements for the amount of bandwidth that is eligible for RHC support – either minimum or maximum thresholds. It should be sufficient simply to establish that supported connections are "solely for purposes reasonably related to health care services or instruction"[48] and that any required match funding has been paid. The HCPs' matching contribution has long been recognized by the Commission as providing sufficient assurance that beneficiaries will not obtain more services than are required. [49] Indeed, comments favorably cited by the Commission in 2003 still apply today: "Sometimes initially higher cost options may prove lower in the long-run, by providing useful

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[47] *See OHN Comments* at 6-7; *see also CoTN Letter* at 2 (noting substantial administrative burden of operating as consortium lead, likelihood of increased costs as network grows, and urging administrative support through proposed Health Infrastructure Program).

[48] *See* 47 C.F.R. § 54.615(c)(4).

[49] *See* NATIONAL BROADBAND PLAN at 215 ("The [15%] match requirement [used in the Pilot Program] aligns incentives and helps ensure that the health care provider values the broadband services being developed and makes financially prudent decisions regarding the project."); *Federal-State Joint Board on Universal Service*, Report and Order, 12 FCC Rcd 8776, ¶ 727 (1997) (*Universal Service Order*) (rejecting additional requirements on HCPs because of adequate program incentives to "not waste their own resources by paying" for services they do not need); *2003 Report and Order and FNPRM*, ¶ 58 (HCP responsibility for "significant portion of service costs" ensures HCPs will select most cost-effective services).

benefits to telemedicine in terms of scalability, maintenance, and future developments."[50] For that reason, the Commission (and USAC) should defer to HCPs regarding the bandwidth of the connections they require.[51]

[50] *See 2003 Report and Order and FNPRM*, at n.189.

[51] *Cf. Request for Review of a Decision by the Universal Service Administrator, Yukon-Kuskokwim Health Corporation, GCI Communication Corp., Rural Health Care Universal Service Support Mechanism*, HCP 10174, *et al.*, CC Docket No. 02-60, Order, ¶¶ 7,8 (rel. May 9, 2010) (reversing USAC decision withholding funding for 3 Mbps connections where USAC had concluded that the connections were being underutilized).

III. CONCLUSION

The programs and policies of the FCC will directly influence the success or failure of true health care reform in our country. The FCC Rural Health Care program took a leap forward with the Pilot Program and the award to OHN – and the rural citizens of Oregon – could not be more grateful or more pleased with the results. We urge the Commission to take another step forward with this important program.

Respectfully submitted,

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May 25, 2012

EXHIBIT A

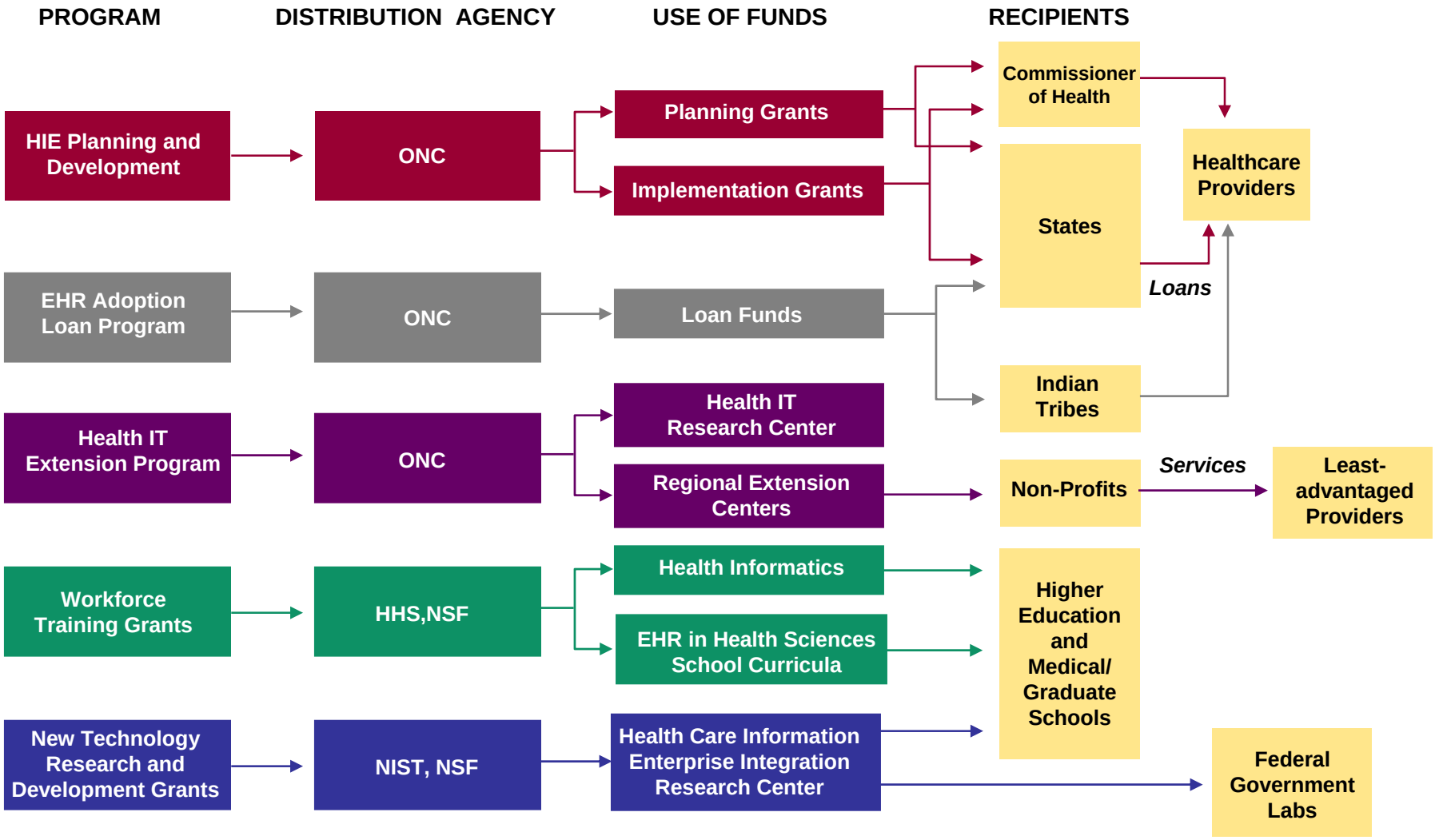
(HITECH ACT: Overview and Estimated Timeline)

HITECH Act

Overview and Estimated Timeline

Key Program, Distribution, Use and Recipients for the HITECH Act*

ONC Focused Funds ($2 billion)

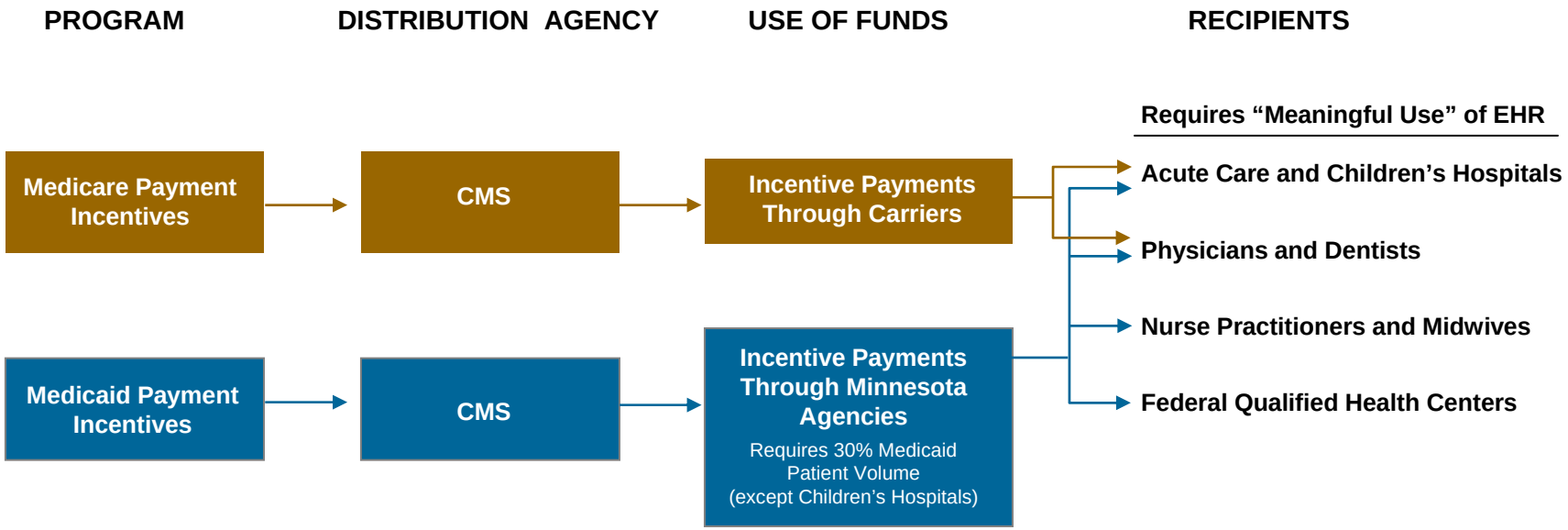


* **Adapted from Minnesota e-Health Initiative Public Meeting on the HITECH ACT on March 18, 2009**

CMS – Center for Medicare and Medicaid Services
HHS – U.S. Dept. of Health and Human Services
HIE – Health Information Exchange
EHR – Electronic Health Record
ONC – Office of the National Coordinator for Health Information Technology
NSF – National Science Foundation
HITECH – Health Information Technology part of the American Recovery & Revetment Act of 2009
NIST – National Institute of Standards and Technology

Key Program, Distribution, Use and Recipients for the HITECH Act*

CMS Funds ($29 billion)



*** Adapted from Minnesota e-Health Initiative Public Meeting on the HITECH ACT on March 18, 2009**

CMS – Center for Medicare and Medicaid Services
HHS – U.S. Dept. of Health and Human Services
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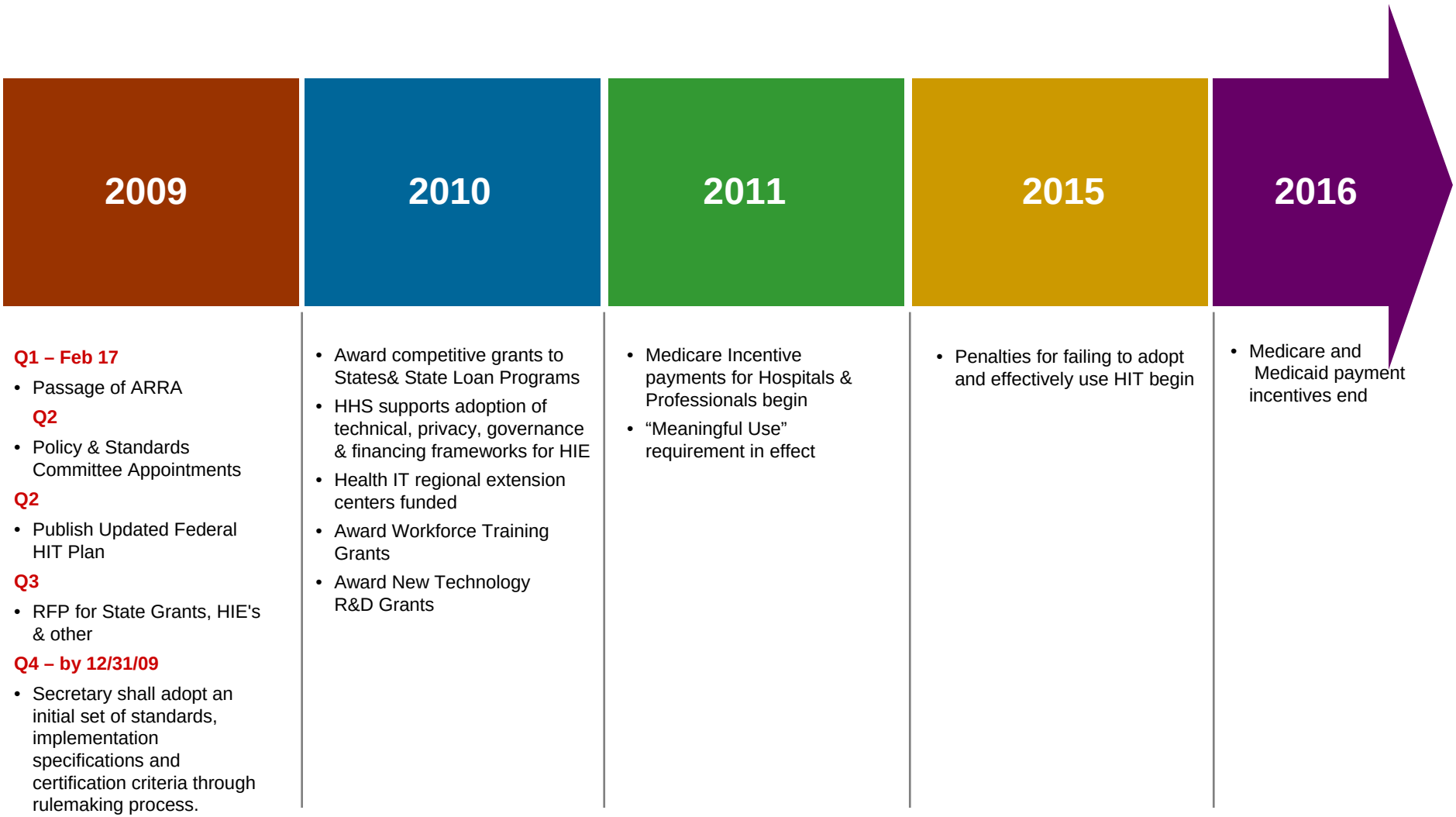
NIST – National Institute of Standards and Technology

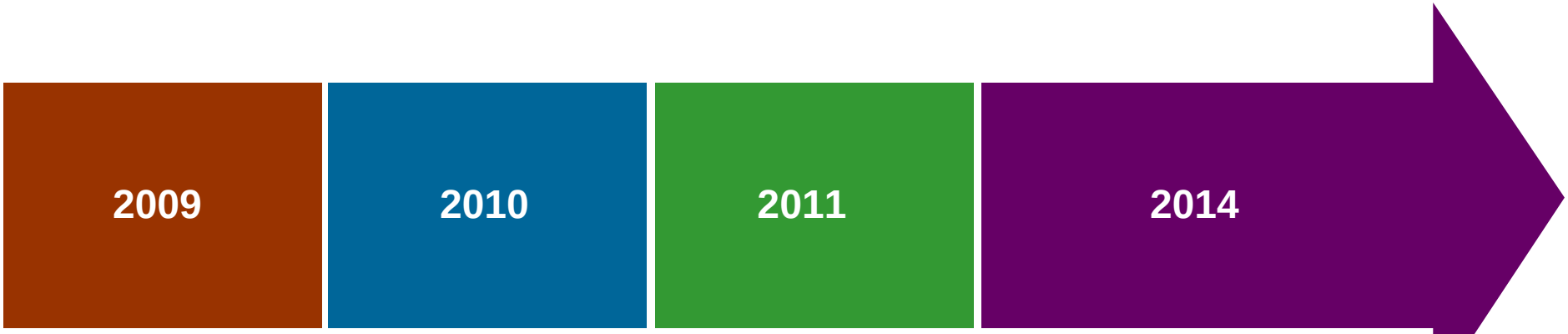
Timeline of Key National HITECH Related Activities*

All timeframes are estimated, unless specified in HITECH



* **Adapted from Minnesota e-Health Initiative Public Meeting on the HITECH ACT on March 18, 2009**

Timeline of Key National HITECH HIPAA Related Activities*



2/17/09
- Penalties increase after this date

4/18/09
- Guidance re unsecured PHI to be issued; 30 days following, those affected by breach of PHI must be notified; and a log kept

8/16/09
- Interim final REGS re duty to notify to be issued
- Requirements for disclosures to individuals to be defined

2/17/10
- BA's directly subject to HIPAA rule, penalties and enforcement
  - ORGS providing data transmission SVCS to a CE or another BA are deemed a BA
  - If CE uses or maintains EHR containing PHI, INDV may request copies in e-format
  - Marketing and fund raising restrictions take effect

8/17/10
- Guidance on "minimum necessary" data sets to be issued
  - Regulations on enforcement provisions to be issued

1/1/11
- If CE's EHR was purchased after 1/1/09, accounting requirements apply

1/1/14
- If CE's EHR was purchased prior to 1/1/09, accounting requirements apply

CE = covered entity
BA = business associate
INDV = individual
SVCS = services
ORG(s) = organization(s)
REGS = regulations

*** Adapted from Minnesota e-Health Initiative Public Meeting on the HITECH ACT on March 18, 2009**